

Provider Application
State Loan Repayment Program of Kansas

Prior to completing the application, review the following health care provider requirements:

This application form is used to determine provider eligibility for local participation in the State Loan Repayment Program of Kansas (State LRP). If you need additional space to answer any of the questions, attach as many pages as needed: type your name, title, and agency at the top of each page.
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1. Must be a resident of Kansas.
2. Must be United States citizen.
3. Provider is not eligible to participate if he/she has previously incurred an obligation for health professional service to the Federal, State, or local government, or other entity unless the obligation is completely satisfied prior to the beginning of service under this program.
4. Provider is not eligible to participate if a breach of obligation has occurred for health professional service to the Federal Government, a State Government or other entity.
5. Provider is not allowed credit for any practice done while the provider is in a professional school or graduate training program.
6. Provider is not allowed loan repayment for any professional practice performed prior to the effective date of the health professional's State LRP contract.
7. Must serve in the clinical practice of his/her profession full time (40 hours per week).
8. Must charge for professional services at the usual and customary rates prevailing in the areas in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee.
9. Must apply all loan repayments received from the State LRP to reducing qualifying graduate and undergraduate educational loans.
10. Must agree that, in providing primary health services, he/she will not, in the case of an individual seeking care, discriminate on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be made pursuant to the program established in Title XVIII (Medicare) of the Social Security Act or pursuant to the program established in Title XIX (Medicaid) or Title XXI HealthWave (Children's Health Insurance) of such Act.
11. Must agree to accept assignment under Section 1842(b) (3) (B) (ii) of the Social Security Act for all services for which payment may be made under Part B of Title XVIII and will enter into an appropriate agreement with Kansas Department of Social and Rehabilitation Services (SRS) which administers the State plan for medical assistance under Title XIX and XXI of such Act to provide service to individuals entitled to medical assistance under the plan.

Criteria used to determine provider eligibility include:

1. Completion of the appropriate level of education. Board certified or eligible for board certification if a physician.
2. Willingness to accept Medicare assignment.
3. Acceptance of Medicaid and HealthWave patients in practice.
4. Willingness to provide services regardless of the patients ability to pay and to use a sliding fee schedule based upon the client's income and the current federal poverty guidelines.
5. Availability to provide care as outlined in the loan repayment contract entered into with an approved site with a minimum of two years service.
6. Demonstration of commitment to serve in medically underserved areas, especially rural areas.

Applicants will also be evaluated on their capability to become board certified or otherwise state or professionally credentialed, academic or professional achievements and professional recommendations.

Supporting documents should include:

1. ☐ Copy of Kansas License.
2. ☐ Proof of Citizenship and Local Kansas residence.
3. ☐ Proof of qualifying educational loans.
4. ☐ Loan Information and Verification Form

Loan Repayment Application

Applicant information:

Name and credential of
Applicant: _____

Kansas License Number / Licensing Agency or Board: _____

Applicant Address: _____

Phone #: _____ E-mail (optional): _____

Signature

Date of Application

Contact information for community/loan payment employer:

Name: _____

Employer Address: _____

Phone #: _____ E-mail (optional): _____

Return this application to:

Kansas Department of Health and Environment
State Loan Repayment Program of Kansas
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365

INSTRUCTIONS FOR COMPLETING THE LOAN INFORMATION FORM

Please complete one Loan Information Form for each loan you wish the State LRP to consider for repayment. This form authorizes your lender to release information about your loan to the State LRP. (If you need additional forms, you may photocopy the blank.) These forms must be enclosed with your application.

Do not send the Loan Information Form to your Lender. The State Loan Repayment Program office will forward these forms to your lenders to verify the loan amounts, balances, and purposes of the loans.

LOAN CONSOLIDATION: If you have consolidated your loans, you may fill out one loan form for the consolidation, but you must list the date of the first loan in #10 and the total amount of the consolidated loan in #11. Attach a list of the dates of origination and amounts for each loan that has been consolidated.

State Loan Repayment Program participants will receive monies to be applied to the principal, interest, and related expenses of Government (Federal, State, or local) and commercial loans obtained by the participant for:

- a. school tuition and required fees;
- b. other reasonable educational expenses; and
- c. reasonable living expenses

incurred by the participant for undergraduate or graduate education leading to a degree in the health profession in which the participant will satisfy his or her State Loan Repayment Program service commitment.

Note: Do not send this form to your lender. Submit it with the application.

LOAN INFORMATION AND VERIFICATION FORM

STATE LOAN REPAYMENT PROGRAM OF KANSAS

The following information must be provided for each loan you are applying to have repaid under the State Loan Repayment Program. Print clearly and completely to help expedite verification. Please note that incomplete information may delay verification of your loan.

INSTRUCTIONS:

APPLICANT: Complete one copy of this form for each loan you are applying to be considered for repayment under the State Loan Repayment Program. To each form, attach a copy of the loan agreement; also attach a copy of your loan application, if possible. Please complete all fields and print clearly to expedite verification.

1. _____
Applicant's Name (Last, First Middle)
2. _____
Applicant's Social Security No.
3. _____
Applicant's Complete Address
4. _____
Applicant's Telephone No.
5. _____
Name of Lending Institution
6. _____
Lender's Phone No.
7. _____
Loan Account No.
8. _____
Full Address of Lending Institution
9. Was the loan sold? ☐ **YES** ☐ **NO** (If you are not sure, check with your lender)

If "yes," give the secondary loan holder's name and full address.
10. Original Date of the Loan _____
11. Original Amount of the Loan _____
12. Current Balance (Principal & Interest) \$ _____ as of (date) _____
13. Interest Rate _____
14. _____
Purpose of the Loan as Indicated on the Loan Application:
15. Type of Loan (e.g., GSL, NDSL, HEAL) Please spell out other type of loan _____
16. Loan in Default? ☐ **YES** ☐ **NO** Date of Default: _____

For Consolidated Undergraduate and Graduate Education Loans: If you have consolidated your loans for undergraduate and graduate education costs, you must attach a copy of the loan documents for health professions education costs that were consolidated into a new loan.

WARNING - Any person who knowingly makes a false statement or misrepresentation in this loan repayment transaction, bribes or attempts to bribe a government official, fraudulently obtains repayment for a loan under this statute, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment under Federal statute. I have read this statement and understand its contents.

CERTIFICATION BY APPLICANT - I hereby certify to the accuracy of the above information and apply to enter into an agreement with the Secretary of KDHE for repayment of the educational loans I have submitted with my application hereof, incurred solely for the costs of education, including reasonable living expense, leading to a degree in medicine, osteopathy, dentistry, or other health profession. I hereby authorize the Government or financial institution named in item 5 or 9 above to release this information about the loan to the administrators of the State Loan Repayment Program of Kansas.

Signature of Applicant

Date